

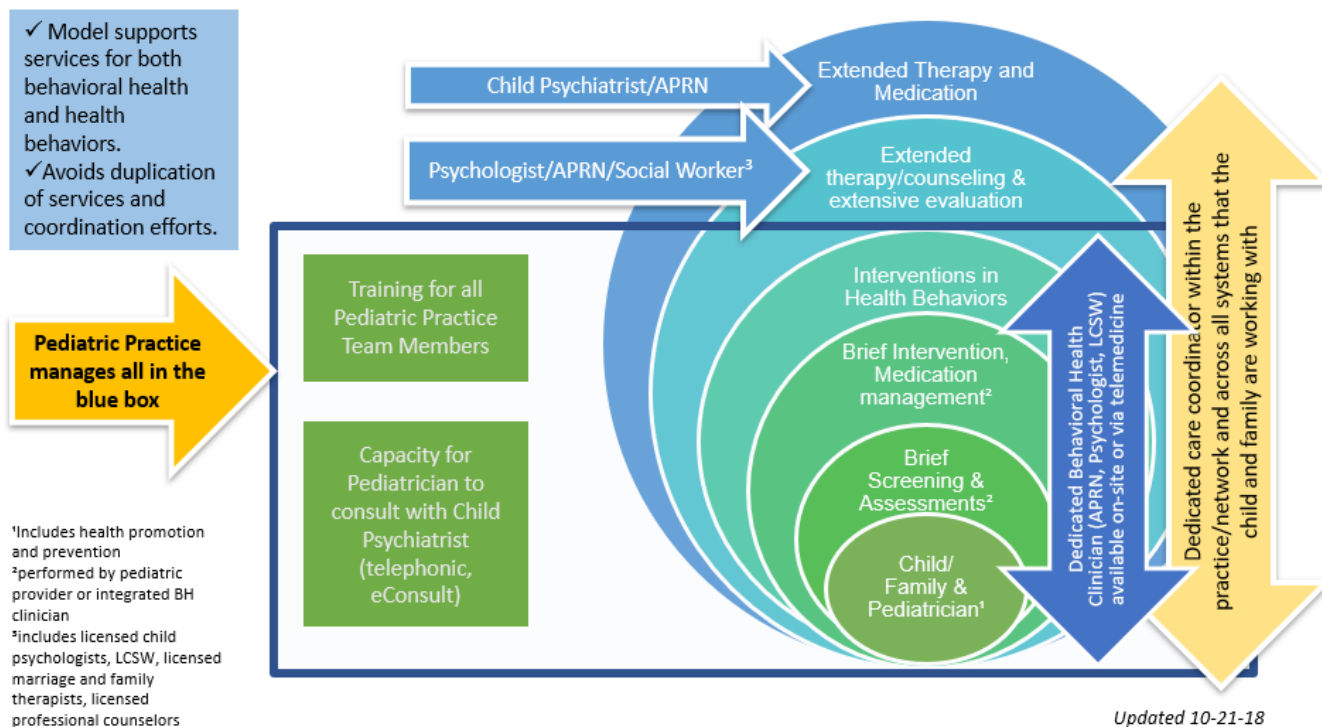
Primary Care Modernization Project Capability Summary

Pediatric Behavioral Health Integration

Definition of the Capability: Provide additional resources and capacity for the pediatric practice to unify pediatric behavioral health and primary care to focus on developmental, socio-emotional, and mental health promotion, prevention and early identification for child and family. The practice supports full integration of dedicated behavioral health clinicians and care coordination functions into primary care, where care coordination involves deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care. The patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient. Care coordination connects children and their families to specialty services and community supports to ensure optimal health and development, address social determinants of health needs and provide culturally and linguistically appropriate health promotion and self-care management education.

Goal of the Capability: Child, family and pediatric clinician are at the center of a well-coordinated, set of behavioral health services integrated within the practice, available in the network and tied to services and resources in the community. This model does not intend to enable pediatric primary care to treat individuals with serious behavioral health conditions, although it does aim to enable primary care to better address these individual's preventive and medical care needs.

PROVISIONAL DRAFT Concept Map: Primary Care Modernization Pediatric Behavioral Health Integration



Addressing Consumer Comments, Questions, Feedback

PCP team training, standard periodic screenings and awareness

- Need for standard screening tools, including developmental, assess the “family health”
- Need for training for pediatric team to expand capability to provide first line care
- Break down silos across disciplines
- Pediatricians are too quick to call in department of children services – which parents felt made them less likely to share information with the pediatrician’s office about behavioral health issues

Expand Care Team

- Some parents felt community health workers could help navigate systems and tackle cultural differences; others expressed concern home visits because of the perceived risk of reporting to child protective services
- “My school severely lacked in helping me with my mental health issues. School was one of the biggest stressors”
- “Cannot expect putting one person in a PCP office will solve the problem of access to specially trained behavioral health professionals”
- Avoid duplication of care coordination services
- Address overmedication in pediatrics and need for periodic re-evaluation
- Refer to ACCESS mental health model to avoid developing a parallel system

Improve access to care

- Address insurance limitations on access and coverage, including long wait times and clinicians who do not accept any insurance plan
- Must measure accountability and performance
- Ensure that payment methodology promotes robust access to treatment and recognizes time needed for implementation

Pediatric Behavioral Health Integration Capabilities

Practice Level

- Specific screenings to assess developmental and socio-emotional health, behavioral health and health behaviors and social and environmental factors that affect the child/family
- Dedicated behavioral health clinician (BHC) for each practice; clinician is integrated into the practice or available via “Warm Handoff” through phone or telemedicine visit
- Dedicated care coordinator with expertise in behavioral health who coordinates within the practice/network and community for child and family; establishes two-way information flow between community and practice.
- Treatment and brief interventions; referral for further treatment if needed

Practice and Network Capabilities

- Medication management expertise within the practice and access to consultations with child psychiatrists
- Patient-to-clinician telemedicine visits (especially for adolescents)
- Tracking outcomes in EHRs
- Training for clinical staff on BH teaming and BH issues and for BH staff on chronic illness
- Referral and coordination with community-based BH specialists for extended therapy, counseling, evaluation and medication

Summary of Design Group Recommendations:

- Support full integration of dedicated behavioral health clinicians and care coordination functions¹ into pediatric primary care for all children.
- Training for pediatric care team:
 - Train primary care team to reduce stigma for patients with behavioral health issues; administering behavioral health screens, enhanced role-based training, and effective teaming with integrated behavioral health clinicians (BHCs), cultural sensitivity and awareness
 - Train BHCs in defined core competencies, such as population care, culture of primary care, common chronic medical conditions, psychopharmacology, brief screening/assessment, brief intervention, brief documentation and effective teaming with pediatric team staff
 - Care coordinator has expertise in addressing both the child *and adult* needs related to behavioral health and social determinants of health
- Prioritize on-site BHCs and use of common EHR platform; use telemedicine as an alternative means to achieve integration for smaller practices
- The practice's dedicated care coordinator works across all systems (school, health, mental health) for each child who needs their care coordinated. Alternatively, the practice can work with a care coordinator that is a contracted position from a care coordination entity, or an employee of another organization that is designated as a care coordinator. The practice's dedicated care coordinator should serve as the care coordinator when no other care coordination resource is involved or available.
- Implement universal screenings at defined intervals to identify issues at an early stage and secondary/indicated screenings as needed (see below for screening recommendations)
- Implement bidirectional communication as needed between the care team and community-based BH specialist, school and community supports
- Enable access to telephonic consultations or eConsults between PCP and behavioral health specialists via ACCESS Mental Health CT service
- Adjust level of behavioral health clinician and care coordination support based on higher illness burden and social determinants of health needs. Work force development will be critical to availability of key functions, including but not limited to: Care coordinators with awareness of/cross training in physical and behavioral health, Marriage and Family Therapists, Pediatric Psychologists, Child Psychiatrists, NPs, Social workers, Community Health Workers and Infant mental health providers
- Develop outcome measures that reflect the effectiveness of the practice in addressing behavioral health needs through actions and activities led by the practice. Include measures that measure the impact on health equity and disparities between populations.
- Create meaningful, actionable measurement and monitoring mechanisms to measure practice's progress in achieving defined goals and capabilities
- Ensure that all appropriate service codes for these roles are covered by payers (and included in primary care payment bundle). Bundle should be adjusted or tiered as practices achieve increased levels of integration.
- Develop an implementation plan and measurement strategy that recognizes the learning curve for activities such as (but not limited to) screenings, team building, care coordination across systems, building community linkages and interpretation and use of new measurement strategies.

¹ Care coordination functions are being defined by the diverse care teams and pediatrics design groups.

Screening Recommendations

--Based on AAP recommendations, to be implemented in stages and on a defined schedule as PCM rolls out

Domain	Age	Sample Screeners or any standardized screening tool evaluated and recommended by the AAP
Universal Screenings		
Developmental	At a minimum: 9, 18, and 24 or 30 months and additional visits at the discretion of the primary care provider	<ul style="list-style-type: none"> Ages and Stages Questionnaires, Third Edition (ASQ-3) Parent Evaluation of Developmental Status (PEDS) The Survey of Well-Being of Young Children (SWYC)
Autism	At 18, 24 or 30 months	<ul style="list-style-type: none"> MCHAT-R/F SWYC 18-, 24-, and 30-month forms
Behavioral Health	At ages 5 - 18 years annually during well-child visits and after a high risk developmental or autism screen, or whenever a concern arises	<ul style="list-style-type: none"> The Survey of Well-Being of Young Children (SWYC) (2 mos. - age 5) Pediatric Symptom Checklist-17 (PSC-17)(ages 4 -18)
Depression	At age 12+	<ul style="list-style-type: none"> Patient Health Questionnaire-9 (PHQ-9): Modified for Teens (ages 12-18)
Substance Abuse	At age 12+	<ul style="list-style-type: none"> The CRAFFT
Postpartum Depression	At 1, 2, 4, and 6 month well-baby visits	<ul style="list-style-type: none"> Edinburgh Postnatal Depression Scale (EPDS)
Secondary/Indicated Screenings		
Trauma	6 to 18 years	<ul style="list-style-type: none"> Child PTSD Symptom Scale (CPSS-5) (8+yrs) Child Trauma Screen (CTS) (6+yrs)
Depression	6 to 17	<ul style="list-style-type: none"> The Center for Epidemiological Studies-Depression Scale for Children (CES-DC)
Anxiety	8-18	<ul style="list-style-type: none"> The Screen for Child Anxiety Related Disorders (SCARED), particularly the brief version
ADHD	6 to 12 6-18	<ul style="list-style-type: none"> Vanderbilt ADHD screening tool (includes comorbid disorders) (parent and teacher versions) SNAP-IV Rating Scale – Revised (SNAP-IV-R)(parent and teacher versions)
Suicide	12+	<ul style="list-style-type: none"> Columbia-Suicide Severity Rating Scale (C-SSRS)